COLORADO
Department of Health Care Policy & Financing

Federal Fiscal Year 2015-16 Hospital Provider Fee and Supplemental Medicaid Payment

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Note: Federal Fiscal Year (FFY) 2015-16 is labeled **Green**, while FFY 2014-15 is labeled **Blue**.

Hospital Provider Fee and Supplemental Medicaid Payment Overview

Provider Fee

- FFY 2015-16 Total Fee: **$667,776,346**
- FFY 2014-15 Total Fee: $688,447,475
- Total Fee Change: ($20,671,129)
- Percent of Inpatient Fee to Total Fee: 57.84%
- Percent of Outpatient Fee to Total Fee: 42.16%

Supplemental Medicaid Payment

- FFY 2015-16 Total Payment: $1,120,811,068
- FFY 2014-15 Total Payment: $1,186,200,172
- Total Payment Change: ($65,389,104)

Net Reimbursement

- FFY 2015-16 Net Reimbursement: $453,034,722
- FFY 2014-15 Net Reimbursement: $497,752,696
- Net Reimbursement Change: ($44,717,974)

Hospital Provider Fee

Hospital Provider Fee

- The inpatient fee is **$355.49** per Non-Managed Care Day. (The FFY 2014-15 inpatient fee was **$340.39** per Non-Managed Care Day - a **$15.10** increase.)

- The outpatient fee is **1.534%** of Total Outpatient Charges. (The FFY 2014-15 percent of Total Outpatient Charges was **1.947%** in FFY 2014-15 – a **.413%** decrease.)

Hospitals Exempt from Hospital Provider Fee

- Medicare Certified Psychiatric (Psychiatric) Hospitals. State mental hospitals and private stand-alone psychiatric facilities that meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR 435.1010.

    - The policy reason for this exemption is due to Federal Financial Participation (FFP) not being available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR 435.1009(a)(2).

- Medicare Certified Long Term Care (LTC) and State Licensed and Medicare Certified Rehabilitation (Rehabilitation) hospitals.

    - The policy reason for this exemption is to incentivize the reduction in uncompensated care cost and increase access for Medicaid and uninsured clients. Both hospital types do not pay the provider fee, but receive additional reimbursement via the supplemental Medicaid payments if they choose to participate in Medicaid.

Hospitals Assessed Discounted Hospital Provider Fee

- The inpatient fee for Managed Care Days is discounted **77.625%**, resulting in a **$79.54** per Managed Care Day fee. (The FFY 2014-15 fee was **$76.16** per Managed Care Day – a **$3.38** increase.)

- The inpatient fee for High Volume Medicaid and Colorado Indigent Care Program (CICP) hospitals is discounted **47.79%**, resulting in a **$41.53** fee per Managed Care Day and a **$185.60** fee per Non-Managed Care Day. (The FFY 2014-15 High Volume Medicaid and CICP hospital fee was **$39.76** per Managed Care Day and **$177.72** per Non-Managed Care Day - a **$1.77** and **$7.88** increase respectively.)

    - High Volume Medicaid and CICP hospitals are hospitals with at least 30,000 Medicaid days per year that provide over 30% of total days to Medicaid and CICP clients.

- The inpatient fee for Essential Access hospitals is discounted **60.00%,** resulting in a **$31.82** fee per Managed Care Day and a **$142.20** fee per Non-Managed Care Day. (The FFY 2014-15 Essential Access fee was **$30.46** per Managed Care Day and **$136.16** per Non-Managed Care Day - a **$1.36** and **$6.04** increase respectively.)

    - An Essential Access hospital is a hospital with 25 or less beds that is also a Critical Access or Rural hospital.

    - A Critical Access hospital is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP.

    - A Rural hospital is a hospital not located within a Metropolitan Statistical Area (MSA) or is located within an outlying county of a MSA as designated by the United States Office of Management & Budget.

- The outpatient fee for High Volume Medicaid and CICP hospitals is discounted **0.84%**, resulting in a fee of **1.521%** of Total Outpatient Charges. (The FFY 2014-15 percent of Total Outpatient Charges was **1.931%** - a **.410%** decrease.)

- The policy reason for discounting fees for Managed Care Days, High Volume CICP hospitals, and Essential Access hospitals is to offset the impact of the managed care days fees discount and meet the B1/B2 test as required by 42 CFR 433.68(e)(2).

- Fee discount percentages are fixed as they were established with the Center for Medicare and Medicaid Services (CMS) in a tax waiver approval letter dated March 31, 2010.

Data Elements Used in Provider Fee

- **Adjusted Total Days** – Total Days excluding Observation Bed Days.

    - **Total Day** - Medicare cost report (Worksheet S-3, Part 1, Column 8) for Cost Report Year End (CRYE) 2013.

    - **Observation Bed Day** – Medicare cost report (Worksheet S-3, Part 1, Column 8, Line 28) for CRYE 2013.

- **Managed Care Day** – Sum of Commercial, Medicaid, Medicare, & Other Managed Care Days as reported by hospitals via the Data Aggregate Report for CRYE 2013.

- **Non-Managed Care Day** – Calculated by subtracting Managed Care Days from Adjusted Total Days.

- **CICP Day** – Days covered under the CICP as reported to the Department for State Fiscal Year (SFY) 2013-14.

- **Total Outpatient Charges** – Medicare cost report (Worksheet C, Column 7, Part 1, Cost Center Lines 50-76 & Lines 90-92) for CRYE 2013.

Hospital Provider Fee Calculation Example

Row	Description	Amount	Calculation
Row 1	Managed Care Days	6,000	
Row 2	Fee Per Managed Care Day	$ 80.00	
Row 3	Managed Care Day Fee	$ 480,000	Row 1 * Row 2
Row 4	Non-Managed Care Days	30,000	
Row 5	Fee Per Non-Managed Care Day	$ 350.00	
Row 6	Non-Managed Care Day Fee	$ 10,500,000	Row 4 * Row 5
Row 7	Total Inpatient Fee	$ 10,980,000	Row 3 + Row 6
Row 8	Outpatient Charges	$ 50,000,000	
Row 9	Fee Percentage	1.500%	
Row 10	Total Outpatient Fee	$ 750,000	Row 8 * Row 9
Row 11	**Total Provider Fee**	**$ 11,730,000**	**Row 7 + Row 10**

** Calculations may not match exactly due to rounding*

Hospital Provider Fee Supplemental Medicaid Payments

Inpatient Base Rate Supplemental Medicaid Payment

- The Inpatient Base Rate Supplemental Medicaid Payment equals the Medicaid Rate Before Add-ons, multiplied by a Percentage Adjustment Factor, multiplied by Case Mix, multiplied by Estimated Medicaid Discharges.

- The Percentage Adjustment Factor varies depending on a hospital's classification. A hospital's Percentage Adjustment Factor is based on the criteria first met using the following list. The order of hospital classifications and corresponding Percentage Adjustment Factors are:

    1) Rehabilitation/LTC Hospital – 5.00%,
    2) State Government Hospital – **19.42%**,
    3) Non-State Government High Volume Government Hospital – **25.00%**,
    4) Non-State Government Teaching Hospital – **32.00%**,
    5) Non-State Government Rural Hospital – **103.00%**,
    6) Non-State Government Hospital – **27.82%**,
    7) Pediatric Hospital – **9.30%**,
    8) Private Rural Hospital – **132.03%**,
    9) Private Neonatal Intensive Care Unit (NICU) Hospital – **128.06%**,
    10) Private Non-Denver Metro Hospital – **119.37%**, and
    11) Private Hospital – **51.50%**.

- A NICU Hospital is a hospital with a level 3B or 3C NICU.

- A non-Denver Metro Hospital is a hospital located in a Metropolitan Statistical Area (MSA) outside of the Denver-Aurora Combined Statistical Area (CSA) with a population between 125,000 and 325,000.

- Psychiatric Hospitals do not qualify for this payment.

- The Inpatient Base Rate Supplemental Medicaid Payment is **$456,818,677**. (The FFY 2014-15 Inpatient Base Rate Supplemental Medicaid Payment was **$606,802,346** - a **$149,983,669** decrease.)

Data Elements Used in Inpatient Base Rate Supplemental Medicaid Payment

- **Medicaid Rate Before Add-ons** – SFY 2015-16 Inpatient Medicaid Rate before Nursery, NICU, and Graduate Medical Education (GME) Add-ons and Budget actions.

- **Estimated Medicaid Discharge** – Medicaid discharges per the Medicaid Management Information System (MMIS) for SFY 2013-14, inflated by estimated Medicaid caseload growth: 34.87% for SFY 2014-15 and 11.05% for SFY 2015-16.

- **Case Mix** – Measure of the relative resource intensity of services provided to patients using MMIS pulled data for SFY 2013-14.

Inpatient Base Rate Supplemental Medicaid Payment Calculation Example

Row	Description	Amount	Calculation
Row 1	Medicaid Rate Before Add-ons	$ 6,000	
Row 2	Percentage Adjustment Factor	50.00%	
Row 3	Incremental Medicaid Rate Before Add-ons	$ 3,000	Row 1 * Row 2
Row 4	Estimated Medicaid Discharges	1,000	
Row 5	Case Mix	1.05	
Row 6	**IP Base Rate Supplemental Medicaid Payment**	**$ 3,150,000**	**Row 3 * Row 4 * Row 5**

** Calculations may not match exactly due to rounding*

Outpatient Supplemental Medicaid Payment

- The Outpatient Supplemental Medicaid Payment equals Estimated Medicaid Outpatient Cost multiplied by a Percentage Adjustment Factor.

- The Percentage Adjustment Factor varies depending on a hospital's classification. A hospital's Percentage Adjustment Factor is based on the criteria first met using the following list. The order of hospital classifications and corresponding Percentage Adjustment Factors are:

    1) Rehabilitation/LTC Hospital – **5.00%**,
    2) State Government Hospital – **28.97%**,
    3) Non-State Government Rural Hospital – **53.94%**,
    4) Non-State Government Hospital – **18.64%**,
    5) Pediatric Hospital – **9.40%**,
    6) Private Rural Hospital – **43.35%**,
    7) Private NICU Hospital – **51.07%**,
    8) Private Non-Denver Metro Hospital – **43.00%**, and
    9) Private Hospital – **27.30%**.

- Psychiatric Hospitals do not qualify for this payment.

- The Outpatient Supplemental Medicaid Payment is **$265,534,622.** (The FFY 2014-15 Outpatient Supplemental Medicaid Payment was **$207,647,024**, a **$57,887,598** increase.)

Data Elements Used in Outpatient Supplemental Medicaid Payment

- **Estimated Medicaid Outpatient Cost** – CRYE 2013 Medicaid Outpatient Cost forecasted to FFY 2015-16 using Outpatient Utilization Inflation and Cost Inflation Factors.
    - **Medicaid Outpatient Cost** – Medicaid Outpatient Charges multiplied by the Total Ancillary Cost to Charge Ratio (CCR).
        - **Medicaid Outpatient Charges** – Pulled from MMIS for CRYE 2013**.**
        - **Total Ancillary CCR –** Total Ancillary Cost divided by Total Ancillary Charges.
            i. **Total Ancillary Cost** – From Medicare cost report (Worksheet C, Part 1, Column 1, Lines 50-76 & Lines 90-92) for CRYE 2013.
            ii. **Total Ancillary Charges –** From Medicare cost report (Worksheet C, Part 1, Column 8, Lines 50-76 & Lines 90-92) for CRYE 2013.
- **Outpatient Utilization Inflation Factor** – The percent change in Medicaid outpatient visits as a function of Medicaid caseload growth for SFY 2014, SFY 2015, & SFY 2016.

  The Outpatient Utilization Inflation adjustments are:

State Fiscal Year	2014	2015	2016
Percent Adjustment	27.20%	37.72%	9.95%

- **Cost Inflation Adjustment Factor** – The percent change in projected market basket increases to Hospital Prospective Payment System (PPS) rates.

  The Cost Inflation adjustments are:

State Fiscal Year	2014	2015	2016
Percent Adjustment	2.70%	2.53%	2.80%

Outpatient Supplemental Medicaid Payment Calculation Example

Row	Description	Amount	Calculation
Row 1	Estimated Medicaid OP Cost	$ 1,000,000	
Row 2	Percentage Adjustment Factor	27.30%	
Row 3	**OP Supplemental Medicaid Payment**	**$ 273,000**	**Row 1 * Row 2**

** Calculations may not match exactly due to rounding*

Uncompensated Care Supplemental Medicaid Payment

- The Uncompensated Care Supplemental Medicaid Payment for qualified hospitals with 25 or less beds equals a hospital's percent of beds to total beds for all qualified hospitals with 25 or less beds, multiplied by **$23,500,008**. The Uncompensated Care Supplemental Medicaid Payment for qualified hospitals with more than 25 beds is a hospital's percent of Uninsured Cost to Total Uninsured Cost for all qualified hospitals with more than 25 beds, multiplied by **$91,980,173**.

- Psychiatric hospitals, LTC hospitals, and Rehabilitation hospitals do not qualify for this payment.

  The Uncompensated Care Supplemental Medicaid Payment is **$115,480,181,** which is a negligible change from FFY 2014-15.

Data Elements Used in Uncompensated Care Supplemental Medicaid Payment

- **Bed Count** – Maximum number of patient beds a hospital holds a license to operate using data from the Colorado Department of Public Health and Environment (CDPHE) website.

- **Total Uninsured Cost** – Total Uninsured Cost as reported by hospitals via the Data Aggregate Report for CRYE 2013.

Uncompensated Care Supplemental Medicaid Payment Calculation
Example for a Hospital With Less Than 25 beds

Row	Description	Amount	Calculation
Row 1	Bed Count	7	
Row 2	25 or Less Beds	True	Row 1 <=25
Row 3	Total Beds for Qualified Hospitals with 25 or Less Beds	700	
Row 4	Percent of Beds to Total Beds for Qualified Hospitals with 25 or Less Beds	1.00%	Row 1 / Row 3
Row 5	Total Available Funds	$ 23,500,000	
Row 6	**Uncompensated Care Supplemental Medicaid Payment**	**$ 235,000**	**Row 4 * Row 5**

** Calculations may not match exactly due to rounding*

Uncompensated Care Supplemental Medicaid Payment Calculation
Example for a Hospital With More Than 25 beds

Row	Description	Amount	Calculation
Row 1	Bed Count	30	
Row 2	25 or Less Beds	False	Row 1 <=25
Row 3	Uninsured Cost	$ 5,000,000	
Row 4	Total Uninsured Cost for Qualified Hospitals with more than 25 beds	$ 500,000,000	
Row 5	Percent of Uninsured Cost to Total Uninsured Cost for Qualified Hospitals with more than 25 beds	1.00%	Row 3 / Row 4
Row 6	Total Available Funds	$ 91,980,176	
Row 7	**Uncompensated Care Supplemental Medicaid Payment**	**$ 919,801**	**Row 5 * Row 6**

** Calculations may not match exactly due to rounding*

Disproportionate Share Hospital (DSH) Supplemental Payment

- The DSH Supplemental Payment equals 100% of the hospital-specific Estimated DSH Limit for qualified hospitals with CICP write-off cost more than 750% of the average hospital CICP write-off cost and 96% of the hospital-specific Estimated DSH Limit for other qualified hospitals with CICP write-off cost less than 750% but more than 200% of the average CICP write-off cost. The DSH Supplemental Payment for all remaining qualified hospitals equals each hospital's Uninsured Costs as a percentage of total Uninsured Cost for all remaining qualified hospitals, multiplied by the remaining DSH Allotment in Total.

- Any Qualified hospital with CICP write-off cost less than 200% of the average CICP write-off cost with a DSH Supplemental Payment greater than or equal to 96% of their Estimated DSH Limit will have their DSH Supplemental Payment reduced to 96% of their Estimated DSH Limit. The reduction will be redistributed to other qualified hospitals with CICP write-off cost less than 200% of the average CICP write-off cost not exceeding 96% of their Estimated DSH Limit based on their percentage of Uninsured Cost to total Uninsured Cost for all qualified hospitals with CICP write-off cost less than 200% of the average CICP write-off cost not exceeding 96% of their Estimated DSH Limit.

- To qualify for the DSH Supplemental Payment a Colorado hospital shall meet either of the following criteria:

    i. Is not a Psychiatric Hospital, is a CICP hospital, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act (SSA); or

    ii. Is not a Psychiatric Hospital, has a Medicaid Inpatient Utilization Rate (MIUR) equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the SSA.

- The DSH Supplemental Payment is **$198,201,052**. (The FFY 2014-15 DSH Supplemental Medicaid Payment was **$194,901,544** - a **$3,299,508** increase.)

Data Elements Used in DSH Supplemental Payment

- **DSH Allotment in Total** – Calculated using the FFY 2016 Federal DSH allotment of $100,527,574, increased by the 49.28% State Share.

- **Estimated DSH Limit** – Total Medicaid & Uninsured Cost minus Estimated Medicaid Payment.

    - **Total Medicaid & Uninsured Cost** – Sum of Total Medicaid Inpatient Cost, Total Medicaid Outpatient Cost, Total Uninsured Cost, and Total Provider Fee Cost.

- **Total Medicaid Inpatient Cost** – Sum of Medicaid Inpatient Cost and Inpatient Dual Eligible Cost as reported by hospitals via the Data Aggregate Report for CRYE 2013.

- **Total Medicaid Outpatient Cost** – Sum of Medicaid Outpatient Cost and Outpatient Dual Eligible Cost as reported by hospitals via the Data Aggregate Report for CRYE 2013.

- **Total Uninsured Cost** – Sum of Inpatient Uninsured Cost and Outpatient Uninsured Cost as reported by hospitals via the Data Aggregate Report for CRYE 2013.

- **Total Provider Fee Cost** – Sum of Inpatient and Outpatient Provider Fee Cost. This is the sum of:

    i. Percent of CRYE 2013 Inpatient Medicaid Day Utilization multiplied by FFY 2012-13 Inpatient Provider Fee,
    ii. Percent of CRYE 2013 Inpatient Uninsured Day Utilization multiplied by FFY 2012-13 Inpatient Provider Fee,
    iii. Percent of CRYE 2013 Outpatient Medicaid Charge Utilization multiplied by FFY 2012-13 Outpatient Provider Fee, and
    iv. Percent of CRYE 2013 Outpatient Uninsured Charge Utilization multiplied by FFY 2012-13 Outpatient Provider Fee.

- **Estimated Medicaid Payment** – Sum of Estimated Inpatient MMIS Medicaid Payment, Estimated Outpatient MMIS Medicaid Payment, Inpatient Base Rate Supplemental Medicaid Payment, Outpatient Supplemental Medicaid Payment, Uncompensated Care Supplemental Medicaid Payment, HQIP Supplemental Medicaid Payment, Non-House Bill (H.B.) 1293 Supplemental Medicaid Payment, Other Payment, and Medicare Dual Eligible Payment.

    - **Estimated Inpatient MMIS Medicaid Payment** – Medicaid Rate Before Add-ons, multiplied by Medicaid Discharges, multiplied by Case Mix.

        i. **Medicaid Rate Before Add-ons** – SFY 2015-16 Inpatient Medicaid Rate before Nursery, NICU, or GME Add-ons and Budget actions.
        ii. **Medicaid Discharges** – Number of Medicaid client discharges pulled from MMIS for SFY 2014-15.
        iii. **Case Mix** - Measure of the relative resource intensity of services provided to patients using MMIS pulled data for SFY 2014-15.
    - **Estimated Outpatient MMIS Medicaid Payment** – Estimated Medicaid Outpatient Cost multiplied by the Cost-to-Payment Percentage of 72.00%. Calculation of Estimated Medicaid Outpatient Cost is discussed starting on Page 9 of this document.

    - **Inpatient Base Rate Supplemental Medicaid Payment** - Calculation of this payment is discussed starting on Page 6 of this document.

- **Outpatient Supplemental Medicaid Payment** - Calculation of this payment is discussed starting on Page 8 of this document.
- **Uncompensated Care Supplemental Medicaid Payment** - Calculation of this payment is discussed starting on Page 10 of this document.
- **Hospital Quality Incentive Care Payment** - Calculation of this payment is discussed starting on Page 17 of this document.
- **Non-H.B. 1293 Supplemental Medicaid Payment** – Non-Provider Fee funded supplemental Medicaid payments including Family Medicaid/GME, Rural Family Medicine, Clinic Based Indigent Care, Pediatric Specialty Hospital, and State University Teaching Supplemental Medicaid Payments for SFY 2015-16.
- **Other Payment** – Sum of in-state and out-of-state Inpatient and Outpatient Other Payments (TPL, Copay, Etc.) as reported by hospitals via the Data Aggregate Report for CRYE 2013.
- **Medicare Dual Eligible Payment** - Sum of in-state and out-of-state Inpatient and Outpatient Medicare Eligible Dual Payments as reported by hospitals via the Data Aggregate Report for CRYE 2013.

- **CICP Write-Off Cost** – Per the Medically Indigent and CICP SFY 2013-14 Annual Report.

Total Uninsured Cost – Sum of Inpatient Uninsured Cost and Outpatient Uninsured Cost as reported by hospitals via the Data Aggregate Report for CRYE 2013.

DSH Supplemental Payment Calculation Example for hospital with DSH Supplemental Payment Less Than 96% Of Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Total IP Medicaid Cost	$ 6,000,000	
Row 2	Total OP Medicaid Cost	$ 3,000,000	
Row 3	Total Uninsured Cost	$ 500,000	
Row 4	Total Provider Fee Cost	$ 500,000	
Row 5	Total Cost	$ 10,000,000	Sum Row 1 through Row 4
Row 6	IP Base Rate Supplemental Medicaid Payment	$ 2,000,000	
Row 7	Estimated IP MMIS Medicaid Payment	$ 1,000,000	
Row 8	OP Supplemental Medicaid Payment	$ 1,500,000	
Row 9	Estimated OP MMIS Medicaid Payment	$ 1,000,000	
Row 10	Uncompensated Care Supplemental Medicaid Payment	$ 500,000	
Row 11	HQIP Supplemental Medicaid Payment	$ 250,000	
Row 12	Non-H.B. 1293 Supplemental Medicaid Payment	$ 0	
Row 13	Other Payment	$ 25,000	
Row 14	Medicare Dual Eligible Payment	$ 25,000	
Row 15	Total Payment	$ 6,300,000	Sum Row 6 through Row 14
Row 16	Estimated DSH Limit	$ 3,700,000	Row 5 – Row 15
Row 17	96% of Estimated DSH Limit	$ 3,552,000	Row 16 * 96%
Row 18	Uninsured Cost	$ 500,000	
Row 19	Total Uninsured Cost for all Qualified Hospitals	$ 50,000,000	
Row 20	Percent of Uninsured Cost to Total Uninsured Cost for all Qualified Hospitals	1.00%	Row 18 / Row 19
Row 21	DSH Allotment in Total	$ 198,201,053	
Row 22	DSH Payment	$ 1,982,011	Row 20 * Row 21
Row 23	**DSH Supplemental Payment**	**$ 1,982,011**	**Lesser of Row 17 and Row 22**

** Calculations may not match exactly due to rounding*

DSH Supplemental Payment Calculation Example for hospital with DSH Supplemental Payment More Than 96% Of Estimated DSH Limit

Row	Description	Amount	Calculation
Row 1	Total IP Medicaid Cost	$ 6,000,000	
Row 2	Total OP Medicaid Cost	$ 3,000,000	
Row 3	Total Uninsured Cost	$ 500,000	
Row 4	Total Provider Fee Cost	$ 500,000	
Row 5	Total Cost	$ 10,000,000	Sum Row 1 through Row 4
Row 6	IP Base Rate Supplemental Medicaid Payment	$ 2,000,000	
Row 7	Estimated IP MMIS Medicaid Payment	$ 1,000,000	
Row 8	OP Supplemental Medicaid Payment	$ 1,500,000	
Row 9	Estimated OP MMIS Medicaid Payment	$ 1,000,000	
Row 10	Uncompensated Care Supplemental Medicaid Payment	$ 500,000	
Row 11	HQIP Supplemental Medicaid Payment	$ 250,000	
Row 12	Non-H.B. 1293 Supplemental Medicaid Payment	$ 0	
Row 13	Other Payment	$ 25,000	
Row 14	Medicare Dual Eligible Payment	$ 25,000	
Row 15	Total Payment	$ 6,300,000	Sum Row 6 through Row 14
Row 16	Estimated DSH Limit	$ 3,700,000	Row 5 – Row 15
Row 17	96% of Estimated DSH Limit	$ 3,552,000	Row 16 * 96%
Row 18	Uninsured Cost	$ 5,000,000	
Row 19	Total Uninsured Cost for all Qualified Hospitals	$ 50,000,000	
Row 20	Percent of Uninsured Cost to Total Uninsured Cost for all Qualified Hospitals	10.00%	Row 18 / Row 19
Row 21	DSH Allotment in Total	$ 198,201,053	
Row 22	DSH Payment	$ 19,820,105	Row 20 * Row 21
Row 23	**DSH Supplemental Payment**	**$ 3,552,000**	**Lesser of Row 17 and Row 22**

** Calculations may not match exactly due to rounding*

Hospital Quality Incentive Payment (HQIP) Supplemental Medicaid Payment

- The HQIP Supplemental Medicaid Payment is a payment to Colorado hospitals providing services that improve the quality of care and health outcomes for their patients. The HQIP Supplemental Medicaid Payment equals Adjusted Discharge Points multiplied by Dollars Per-Adjusted Discharge Point.

- Psychiatric hospitals do not qualify for this payment.

- The HQIP Supplemental Medicaid Payment is **$84,776,536**. (The FFY 2014-15 HQIP Medicaid Payment was **$61,448,873**, a **$23,327,663** increase.)

Data Elements Used in HQIP Supplemental Medicaid Payment

- **Adjusted Discharge Points** – Total Normalized Awarded Points multiplied by Medicaid Adjusted Discharges.
    - **Total Normalized Awarded Points –** Total Points Awarded divided by Total Points Eligible, multiplied by 50 total possible points.
        - **Total Points Awarded –** Sum of Base Measure Points and Optional Measure Points awarded.
            i. **Base Measure Points** – Points awarded based on established scoring criteria for the following measures:
                I. Emergency department process measure,
                II. Rate of elective deliveries between 37 and 39 weeks gestation,
                III. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,
                IV. Rate of thirty day all-cause hospital readmissions, and
                V. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
            ii. **Optional Measure Points** – If a Base Measure does not apply to a hospital, the hospital may substitute for an Optional Measure. Optional Measures must be selected in the order listed:
                I. Culture of safety,
                II. Active participation in a Regional Care Collaborative Organization (RCCO),

III. Advance care planning, and

IV. Screening for tobacco use.

- **Total Points Eligible** – Both Base and Optional Measures are scored out of ten possible points. The count of Base and Optional Measures with awarded points multiplied by ten.

- **Medicaid Adjusted Discharges –** Gross Medicaid Charges divided by Gross Inpatient Medicaid Charges, multiplied by Medicaid Discharges.
  - **Gross Medicaid Charges –** Pulled from MMIS for CY 2014.
  - **Gross Inpatient Medicaid Charges –** pulled from MMIS for CY 2014.
  - **Medicaid Discharges –** Pulled from MMIS for CY 2014.

Note – For hospitals with less than 200 Medicaid Discharges, the total number of Medicaid discharges is multiplied by 125%.

- **Dollars Per-Adjusted Discharge Point –** Dollars Per-Adjusted Discharge Point is tiered so that hospitals with more Total Normalized Points Awarded receive a greater Per-Adjusted Discharge Point reimbursement. The Dollars Per-Adjusted Discharge Point for the five tiers are shown in the table below:

Tier	Total Normalized Awarded Points	Dollars Per-Adjusted Discharge Point
1	1-10	$ 13.18
2	11-20	$ 14.50
3	21-30	$ 15.82
4	31-40	$ 17.13
5	41-50	$ 18.45

HQIP Supplemental Medicaid Payment Calculation

Row	Description	Amount	Calculation
Row 1	Emergency Room Process Base Measure	10	
Row 2	Elective Delivery between 37 and 39 Weeks Gestation Base Measure	5	
Row 3	Cesarean Section Base Measure	5	
Row 4	30-Day All-Cause Readmissions Base Measure	0	
Row 5	HCAHPS Base Measure	8	
Row 6	Total Base Measure Points Awarded	28	Sum of Row 1 through Row 5
Row 7	Culture of Safety Optional Measure	2	
Row 8	Active Participation in RCCO's Optional Measure	0	
Row 9	Advance Care Planning Optional Measure	0	
Row 10	Tobacco Screening Optional Measure	0	
Row 11	Total Optional Measure Points Awarded	2	Sum of Row 7 through Row 10
Row 12	Total Points Awarded	30	Row 6 + Row 11
Row 13	Total Points Eligible	50	
Row 14	Total Points Awarded To Total Points Eligible	60%	Row 12 / Row 13
Row 15	Total Normalized Awarded Points	30	Row 14 * 50
Row 16	Dollars Per-Adjusted Discharge Point	$ 15.82	If Row 12 between 1 and 10 = $ 13.18 If Row 12 between 11 and 20 = $ 14.50 If Row 12 between 21 and 30 = $ 15.82 If Row 12 between 31 and 40 = $ 17.13 If Row 12 between 41 and 50 = $ 18.45
Row 17	Medicaid Discharges	10,000	
Row 18	Adjusted Discharge Points	300,000	Row 15 * Row 17
Row 19	**HQIP Supplemental Medicaid Payment**	**$ 4,746,000**	**Row 16 * Row 18**